



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 30, 2026

Krystyna Badoni
Portage Bickford Cottage
4707 W. Milham Ave.
Portage, MI 49024

RE: License #: AH390278221
Investigation #: 2026A1028026
Portage Bickford Cottage

Dear Krystyna Badoni:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely,

A handwritten signature in cursive script, appearing to read "Julie Viviano".

Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AH390278221
Investigation #:	2026A1028026
Complaint Receipt Date:	01/27/2026
Investigation Initiation Date:	01/28/2026
Report Due Date:	03/26/2026
Licensee Name:	Portage Bickford Cottage LLC
Licensee Address:	Suite 301 13795 S. Mur-Len Road Olathe, KS 66062
Licensee Telephone #:	(810) 962-2445
Authorized Representative/Administrator:	Krystyna Badoni
Name of Facility:	Portage Bickford Cottage
Facility Address:	4707 W. Milham Ave. Portage, MI 49024
Facility Telephone #:	(269) 390-6610
Original Issuance Date:	03/05/2007
License Status:	REGULAR
Effective Date:	08/01/2025
Expiration Date:	07/31/2026
Capacity:	71
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
The facility did not provide Resident A appropriate care which led to a hospitalization and contributed towards Resident A's death in October 2025.	Yes
Additional Findings	Yes

III. METHODOLOGY

01/27/2026	Special Investigation Intake 2026A1028026
01/28/2026	Special Investigation Initiated - Letter
01/28/2026	APS Referral APS made referral to HFA.
01/29/2026	Contact - Document Sent Email sent to facility administrator and authorized representative (AR) requesting documentation related to special investigation. No onsite investigation because the resident has been deceased since October 2025.
01/29/2026	Contact - Document Sent Sent follow-up email to facility administrator and AR requesting the status of the documentation request.
02/03/2026	Contact - Telephone call made Spoke with facility AR via telephone about status of requested documentation.
02/03/2026	Contact - Document Received Received the requested documentation from the facility AR via email.

This investigation will only address allegations pertaining to potential violations of the rules and regulations for Homes for the Aged (HFA).

ALLEGATION:

The facility did not provide Resident A appropriate care which led to a hospitalization and contributed towards Resident A's death in October 2025.

INVESTIGATION:

On 1/28/2026, the Bureau received the allegations through referral from Adult Protective Services (APS).

On 2/3/2026, I spoke with the facility authorized representative (AR) via the telephone to inquire about the status of the requested documentation related to this special investigation. The facility AR reported [they] would send the documentation by the end of the day.

On 2/3/2026, I received the requested documentation from the facility AR via email.

On 2/23/2026, I reviewed the requested documentation which revealed the following:
Review of the service plan:

- Resident A has a diagnosis of dementia and has difficulty communicating needs.
- Resident A required assistance with bathing, dressing, grooming, oral care, toileting and hygiene, transfers, mobility, and hearing aids care.
- Resident A required reminders and/or cuing to wear glasses, for mealtimes, and to eat.
- Resident A was to receive 4 safety checks per shift due to increased confusion and disorientation.
- Resident A required ongoing redirection due to frequent elopement risk.
- Resident A did not demonstrate behaviors.
- The facility managed all meals, housekeeping, and laundry.
- The service plan was last updated on 9/5/2025.

Review of Chart Notes:

- On 9/4/2025, Resident A moved into the facility.
- On 9/10/2025, Resident A's family member reported *long call-light wait times to facility staff. The facility health and wellness director (HWD) conferenced with Resident A's spouse and family member to address concerns. Weekly updates to keep communication open were offered by the HWD.*
- On 9/18/2025, Resident A *began to cry during dinner and reported [they] were left in the recliner all day.*
- On 9/20/2025 at 3:10 am, Resident A was observed sitting on the bathroom floor when staff completed a safety check. Resident A reported *[they] were not injured and that [they] believed [they] were sleepwalking.*
- On 9/28/2025, Resident A was observed by staff as not feeling well or acting [their self], and not eating even when assisted. Resident A was weak and required increased 2-person assistance for transfers. Resident A's family

member was notified and asked about sending Resident A to the hospital for evaluation. The family member reported [they] would visit the facility that day to determine if Resident A needed to go to the hospital or not. Facility staff on duty notified the HWD as well.

- On 9/29/2025 at 8:30 am, Resident A was observed by staff as *leaning more to the right side and requiring increased assistance to eat breakfast.*
- On 9/30/2025 at 3:07 pm, Resident A was *seated in the recliner and demonstrated a tremor in the right hand and limited response to direction. Vitals: BP – 131/89; HR 91; and O2 84% on room air. Discontinued PT evaluation and notified patient assistant.*
- On 10/1/2025 at 3:03 am, Resident A was *observed sitting on the bathroom floor when staff was performing a safety check. Resident A complained [their] head and back were hurting. Staff noticed a raised area on the back of the head when evaluating for injuries. Staff laid Resident A on bathroom floor with pillow under the head and called for transport to the hospital. Vitals: T 97.8; P 105; R 22; B/P 138/85, PO 95%.*
- On 10/1/2025 at 1:26 pm, Resident A *returned from the hospital and still needs 2-person assistance for transfers.*
- On 10/4/2025 at 7:35 am, Resident A was *found sitting on the floor with [their] walker and crying. Resident A was not able to say what happened. Vitals were taken and range of motion was done. Resident A was transferred from the floor to the wheelchair with the help of another aide. There was no bruise or skin tear. Resident A denies any pain. Resident A was brought to common area so staff can have eyes on [them].*
- On 10/5/2025 at 4:06 am, Resident A *complained of a headache early in the afternoon. PRN pain reliever given and tolerated well. Later in the evening before bed, Resident A started complaining about [their] legs and back hurting. PRN Tylenol given and tolerated well. Once Resident A went to bed after Tylenol, she was able to sleep, only getting up once for the toilet.*
- On 10/6/2025, Resident A's *spouse requested that staff put Resident A in bed around 5:45 pm. Around 8:30 pm, staff heard a loud thud and found Resident A on the floor in the dining area. Vitals were taken, were elevated, and retaken. Injuries: bruised and swollen eye.*
- On 10/7/2025 at 9:44 pm, Resident A *is very confused, could not stay in bed. Staff put Resident A in the recliner in the living room to keep an eye on [them]. Resident A kept getting up every 30 minutes or less without the walker.*
- On 10/11/2025, Resident A was *observed on the floor beside the bed, approximately 5 minutes after being placed in bed. No visible injuries. Family member notified. Vital signs: T 97.5; BP 115/81; P 95; O2 96%.*
- On 10/12/2025 at 2:40 am, Resident A was *walking with staff back from the bathroom to the common area with the walker when Resident A threw the walker and fell backwards hitting [their] head. Life EMS was notified for transport. Message was left with Resident A's family member about incident. Vitals signs were taken: T 96.8; P 99; R 18; B/P 135/85; PO 95%. Injuries: Possible head injury, increased pain.*

- On 10/15/2025, Resident A's *belongings were picked up by the spouse and family member.*

APPLICABLE RULE	
R 325.1921	Governing bodies, administrators, and supervisors.
	<p>(1) The owner, operator, and governing body of a home shall do all of the following:</p> <p>(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.</p> <p>(c) Assure the availability of emergency medical care required by a resident.</p>

<p>ANALYSIS:</p>	<p>It was alleged the facility did not provide Resident A appropriate care which led to a hospitalization and contributed towards Resident A's death in October 2025. It cannot be determined that if the care provided by the facility contributed to Resident A's death in October 2025, but interview of the facility AR along with review of documentation revealed the following:</p> <ul style="list-style-type: none"> • On 9/28/2025, Resident A was observed not feeling well and not eating even when assisted. Resident A demonstrated weakness and required increased 2-person assistance for transfers. While Resident A's family member was notified and asked about sending Resident A to the hospital for evaluation, there is no documentation to determine what further steps were taken by staff to ensure Resident A's health and wellbeing when Resident A demonstrated a change in condition. • On 9/29/2025 at 8:30 am, staff observed Resident A leaning to the right side and requiring increased assistance. At 3:07 pm, Resident A demonstrated a tremor in the right hand and limited response to direction. However, there is no documentation to determine if staff took further action to address the observations to ensure Resident A's health and wellbeing or to determine if Resident A was demonstrating a medical incident that required emergency medical intervention. • Resident A was to receive 4 safety checks per shift. On 10/6/2025, staff put Resident A in bed around 5:45 pm per the spouse's request; and at 8:30 pm, Resident A was found on the floor in the dining area. There is no documentation to support that staff completed the required safety checks which would have provided Resident A with appropriate supervision and potentially prevented the fall with injury. <p>The facility did not provide Resident A with the required supervision, assistance, or seek emergency medical intervention when Resident A began to require increased care and assistance from staff or when Resident A demonstrated a change in condition. Therefore, the facility is in violation.</p>
<p>CONCLUSION:</p>	<p>VIOLATION ESTABLISHED</p>

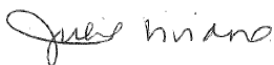
ADDITIONAL FINDINGS:

On 2/23/2026, during the review of the service plan along with the chart notes, it was discovered that there is conflicting information pertaining to the assistance that Resident A required from staff with transfers and mobility.

APPLICABLE RULE	
R 325.1922	Admission and retention of residents.
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
ANALYSIS:	Resident A began to demonstrate the need for 2-person assistance for transfers and mobility on 9/28/2025, however, the service plan was not updated to reflect the need for increased assistance. The service plan was last reviewed by Resident A's family member on 9/5/2025, and it was last updated by the facility's former administrator on 9/26/2025. Also, the service plan has conflicting directives because the first page of Resident A's service plan is marked as "non-ambulatory" but the mobility/transfer section of the service plan shows Resident A only required 1-person partial assistance with resident participation. Due to the service plan not being updated in accordance with Resident A's demonstrated increased care needs, and due to the conflicting mobility and transfer care information in the service plan, the facility is in violation.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

Contingent upon receipt of an approved corrective action plan, I recommend that the status of this license remains the same.



2/24/2026

Julie Viviano
Licensing Staff

Date

Approved By:



03/30/2026

Andrea L. Moore, Manager
Long-Term-Care State Licensing Section

Date